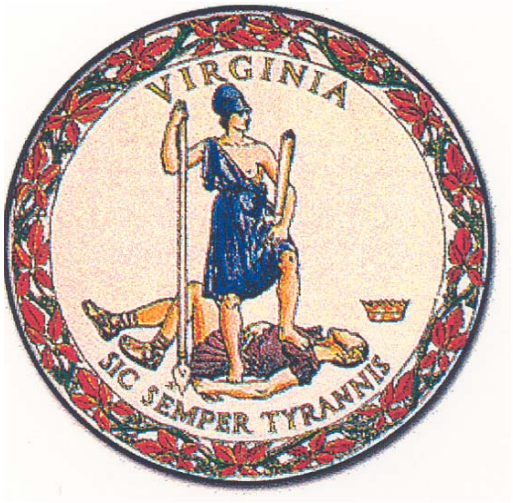

Inspection of
April 16, 2007 Critical Incident
At Virginia Tech

Prepared by:
Office of the Inspector General
For Mental Health, Mental Retardation
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Report: # 140-07

Preliminary Report

Office of the Inspector General for Mental Health, Mental Retardation and Substance Abuse Services

Investigation of April 16, 2007 Critical Incident at Virginia Tech
OIG Report #140-07 (Preliminary Report)

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Office of the Inspector General for Mental Health, Mental Retardation and Substance Abuse Services

Investigation of April 16, 2007 Critical Incident at Virginia Tech
OIG Report #140-07

I. Authority of the Office of the Inspector General

The Office of the Inspector General (OIG) is established by Virginia Code § 37.2-423 to inspect, monitor and review the quality of services provided in the facilities operated by the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) and providers as defined in Virginia Code § 37.2-403. The OIG conducts inspections and makes policy and operational recommendations in order to prevent problems, abuses, and deficiencies in and improve the effectiveness of programs and services. Oversight is provided on an ongoing basis in response to specific complaints of abuse, neglect, or inadequate care and as a result of monitoring serious incident reports and other information received. Findings and recommendations of the OIG are directed to the Office of the Governor, the members of the General Assembly and the Joint Commission on Healthcare.

Virginia Code § 37.2-424(4) authorizes the OIG to access any and all information, including confidential consumer information, related to the delivery of services to consumers in state facilities or served by providers. All consumer information shall be maintained by the Inspector General as confidential in the same manner as is required by the agency or provider from which the information was obtained.

II. The Critical Incident

On April 16, 2007, a 23 year-old male shot and killed 32 students and faculty members, injured another 24 people, and then killed himself on the campus of Virginia Polytechnic Institute and State University (Virginia Tech) in Blacksburg, Virginia. Investigations by law enforcement agencies revealed that the shooter (henceforth referred to as "the individual") was a currently enrolled senior at the university who lived on campus.

The OIG first learned of this critical incident from local, state and national media reports. These reports indicated that on December 13, 2005, the individual had been taken into emergency custody by a Virginia Tech police officer because the police received information indicating that the individual had communicated a statement to a roommate that he may be suicidal. These reports also revealed that the individual had been prescreened for a temporary detention order (TDO) by the New River Valley Community Services Board (CSB) and that a local magistrate had issued a TDO hospitalizing the individual at the St Albans Behavioral Health Center of the Carilion New River Valley Medical Center. The news media also reported that the local Special Justice (SJ), who held a commitment hearing for the individual on December 14, 2005, ordered outpatient

treatment and that a referral for the outpatient treatment had been made to the Cook Counseling Center at Virginia Tech.

III. Investigation Process

During the week of April 23, 2007, the OIG contacted the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) Office of Licensing to determine whether or not that office had conducted an investigation of the services provided by the New River Valley CSB and the St Albans Behavioral Health - Carilion New River Valley Medical Center in connection with this critical incident. It was learned that investigations were underway. The OIG reviewed the facts and very preliminary findings that had been compiled by the Office of Licensing.

In preparation for conducting an investigation of this critical incident, the staff of the OIG reviewed a wide range of articles in local and national newspapers, conducted research regarding relevant cultural background information, and reviewed the records from the New River Valley Community Services Board (CSB) and the Carilion New River Valley Medical Center. On May 24 and 25, 2007, the OIG conducted an on-site investigation in Blacksburg. This included a series of interviews with those who had been involved in the December 13, 2005 temporary detention, hospitalization and commitment hearing process; with others who could provide the OIG with information about the individual from the perspective of his peer relationships, his life on campus, and the university's involvement with him; and with staff of the university who could provide an understanding of established procedures for dealing with troubled students. Interviews were conducted with over 30 individuals including:

- Clinical staff of the New River Valley CSB, including one former employee
- Medical and administrative personnel at the St Albans Behavioral Health - Carilion New River Valley Medical Center
- Independent Examiner
- Special Justice
- Virginia Tech personnel from the following offices:
    - University Legal Counsel
    - Police Department
    - Student Programs
    - Thomas E. Cook Counseling Center
- Virginia Tech students

A listing of the individuals who were interviewed and the documents that were reviewed can be found in Attachment A. The OIG review team included Senior Inspector/Project Manager Cathy L. Hill, LPC, Consulting Psychiatrist Kent G. McDaniel, MD, PhD and Inspector General James W. Stewart, III.

The purpose of this investigation was to formulate recommendations that will improve the response of the community and the mental health system to individuals who are experiencing a psychiatric emergency.

IV. Background Information

Before Fall of 2005

Prior to the fall of 2005, very little is known about the individual's life in the University community. Based on the information collected by the OIG, it appears that he did not stand out from other students in a significant enough way to come to the attention of university officials during the first two years on campus.

From August to December 12, 2005

Between August and December 2005, the fall semester of his junior year, a significant number of incidents involving the individual occurred in which other students and faculty members perceived or experienced his actions or interactions with them as extremely odd, frightening and/or threatening. These incidents occurred in the residence hall, in the classroom and in various forms of communication between the individual and other students and faculty.

Students and faculty members were concerned enough about the individual's behavior to contact various offices within the university including the Virginia Tech Police Department (VTPD) to seek consultation, file complaints, and to request intervention. The diagram in Attachment B depicts the lines of communication that occurred during the fall semester between various parties in the university community regarding incidents that involved the individual. In summary, there was a great deal of communication involving many individuals and offices. This diagram in no way reflects communication that may or may not have occurred between the individual and offices of the university that maintain patient information and records that are protected by federal privacy regulations, including the HIPAA Privacy Rule, 45 C.F.R. Parts 160 and 164, the Virginia Health Records Privacy Act, § 32.1-127.1:03, and Va. Code § 37.2-424(4) and in no way reflects communication that may or may not have been initiated by these same offices.

OIG interviews with students and Residence Life staff who knew the individual well and lived in close proximity to him during the 2005-06 school year made it clear that the individual was not the typical college student, that he exhibited behaviors that were far outside the norm for students, and that they had concerns that he might harm himself or others. Those who lived around him were increasingly cautious about their own safety as the semester proceeded. Following a series of incidents in which the individual was reported to have harassed other students, those who lived close to him took it upon themselves to warn other students about his behavior. At least one student communicated to a Resident Advisor (RA) a desire to move to another building to get away from the individual.

OIG interviews with employees of the university at several different levels revealed the following activities or interventions by university personnel in response to incidents that involved the individual during this period:

- On several occasions, Residence Life staff talked with the individual about complaints received and about concerns they had for him. These staff reported that the individual came to their attention repeatedly and that a number of incident reports and On Call Reports were completed and forwarded to appropriate personnel in Residence Life.

- In response to an instructor's concern about the impact of the individual's behavior on other students in the classroom, this instructor asked for police coverage of the classroom. A special meeting of the university Care Team was held to address this instructor's concern. This team developed a plan for dealing with this incident that included removal of the individual from the classroom, agreement by the department chair to tutor the individual and referral to the Cook Counseling Center. This team is composed of representatives from Judicial Affairs, the Office of the Dean of Students, Residence Life, Cook Counseling Center, Schiffert Health Center (as needed), Women's Center (as needed), and the Associate Vice President for Student Affairs.

- At the request of an instructor, Judicial Affairs reviewed a paper written by the individual for a classroom assignment to determine if university policy had been violated.

- Following an incident in which the individual harassed another student and police warned him to discontinue this behavior, Judicial Affairs provided an opportunity for the victim to file charges with the Office of Judicial Affairs against the individual. These charges were not filed and there was no intervention by Judicial Affairs with the individual.

- On December 12, 2005, police received another complaint about the individual's harassing behavior. When the police investigated at 11:45 a.m. that same day, they learned that there had been a series of harassing communications directed to a student by the individual on December 9, 11 and 12. The student asked the police to tell the individual to have no further contact. The officers told the individual's roommate to tell the individual to contact them at the police department. The police also sent an email to the individual asking him to contact them.

The OIG was informed that on December 12, 2005 one of the individual's suitemates submitted a long statement to an RA detailing the increasing concerns about the individual's escalating bizarre and threatening behavior.

From the beginning of the fall 2005 semester to December 13, 2005, the incidents involving the individual occurred increasingly and were progressively more aggressive and threatening in nature, but did not involve any physical contact with other parties.

From December 13 to 14, 2005

At 11:00 a.m. on December 13, 2005, a police officer met with the individual at his dorm room and informed him of the complaint that was received by the police on December 12, 2005. The officer instructed the student to have no further contact with the complainant and informed him that he had not committed a criminal act but that this type of behavior could result in criminal charges. The individual stated that he understood. No criminal charges were made, and there was no referral to Judicial Affairs.

Around the middle of the day on December 13, 2005, the individual sent an instant message to a roommate relating the events with the police and revealing that he "might as well kill himself or something". At approximately 2:30 p.m. the roommate called his father to report this information. At approximately 3:00 p.m. the individual told his roommate that he was only joking. At 3:42 p.m. the roommate's father called the VTPD to report what his son had told him. The officer interviewed the roommate who told him about the individual's comment and history of strange behavior. The roommate also informed the officer that he and other suitemates had documented all of the odd incidents they could recall involving the individual and had given them to an RA. The police officer contacted the On Call Coordinator for the dorm. The Coordinator told the officer that he was very familiar with the individual and would check on him later in the afternoon.

From the time the roommate's father called the police to around 7:00 p.m., the individual was away from his dorm room. During this time he took an exam and had dinner. At 7:09 p.m., after receiving a call from the roommate that the individual had returned to his dorm room, the VTPD went to the dorm and interviewed the individual. After a brief interaction, in which the individual stated that he was only joking when he sent the instant message, he willingly agreed to speak to a counselor. The police officers took the individual into emergency custody and transported him to the Police Department for an assessment to determine the need for hospitalization or treatment as authorized by Va. Code §37.2- 808(F.). The officers described him as "shy and seeming down" about something. Efforts to engage him were not successful.

At 8:15 p.m. on December 13, 2005, Kathy M. Godbey, LCSW, who worked in the New River Valley CSB Access Program at that time, traveled to the VTPD and conducted a prescreen evaluation (Va. Code § 37.2-809(B)) of the individual. Ms. Godbey is an experienced, licensed clinician and a Certified Prescreener (prescreener).

In her face-to-face interview, the prescreener obtained the following information from the individual. This information is recorded on the Uniform Pre-Admission Screening form:

- Acknowledgement of contact with the female student and the suicidal message to a roommate.

- Denial that he had harassed another student but understanding that this behavior was not welcome.
- Explanation that the suicide message was a joke
- Denial of depression and anxiety and any suicidal thoughts/intentions
- Inability to come up with an adequate safety plan and unwillingness to contact his parents to pick him up.

The prescreener considered three collateral sources of information:

- Police report
- Interview with the detaining police officer. From these first two collateral sources she learned about recent complaints regarding harassing behavior by the individual and the fact that police had received a call from the father of the individual's roommate reporting possible thoughts of suicide on the part of the individual.
- Interview with a student who lived in the same residential suite as the individual from whom she learned that the individual had been acting "bizarre", referring to himself as "?", and referring to an imaginary twin brother. She also learned from this student of an earlier incident of harassing behavior by the individual. She spoke with this suitemate when she was not able to reach the roommate who had direct communication from the individual about possibly being suicidal.

On the New River Valley Uniform Pre-Admission Screening Form the prescreener recorded that she had determined that the individual:

- Is mentally ill (This was supported by a diagnosis of Depressive Disorder, NOS)
- Is an imminent danger to self or others
- Is able to care for self
- Is capable of consenting to voluntary treatment/hospitalization
- Is not willing to be treated voluntarily

She also noted that there are no less restrictive community alternatives (alternatives to hospitalization)

The prescreener made a pre-detention disposition recommendation of involuntary hospitalization because the individual:

- Meets criteria for involuntary hospitalization
- Is capable of consenting to voluntary treatment
- But is unwilling to be treated voluntarily

Regarding discharge planning from the hospital, she recorded that:

- The New River Valley CSB Access Program could assist with treatment and discharge planning.
- Medication management and outpatient services should be considered in planning for discharge.

As per Va. Code § 37.2-809(D), the prescreener determined that a bed for temporary detention was available at the St Albans Behavioral Health Center of the Carilion New

River Valley Medical Center and noted this on the preadmission screening form and on the temporary detention order.

The prescreener informed the OIG that she experienced this case as a routine prescreen. She was not rushed and a bed was readily available at St Albans Behavioral Health Center.

Upon receiving the results of the prescreening, Magistrate Elinor E. Williams issued a TDO at 10:12 p.m. on Tuesday, December 13, 2005 as authorized per Va. Code § 37.2-809(B). The VA Tech police transported the individual to Carilion New River Valley Medical Center at 10:49 p.m. as ordered by Magistrate Williams in the TDO per Va. Code § 37.2-810. The individual was admitted to the St Albans Behavioral Health Unit at 11:15 p.m. on Tuesday, December 13, 2005.

According to hospital personnel, it is standard practice for the authorized Independent Examiner (IE), who is appointed per Va. Code § 37.2-815 to begin conducting the independent evaluations at 7:00 a.m. on the day of the hearing for all persons who are detained at St Albans Behavioral Health Center. At approximately 7:00 a.m. on December 14, 2005, Roy Crouse, PhD. evaluated the individual in a private room in the St Albans Behavioral Health Center. Dr. Crouse is an experienced and licensed clinical psychologist who has served as an IE for 22 years. He reported to the OIG that he usually takes 10 to 30 minutes to conduct an evaluation. The only information that is routinely reviewed by the IE is the prescreener's Pre-Admission Screening Form. He also reported that while he has access to the hospital's records regarding the subject of his evaluations and can seek information from the attending physician, he only does this when the case is unclear. He reported to the OIG that he did not review the hospital record or talk to the attending physician in connection with his evaluation of this individual. As noted on the Proceedings for Certification for Involuntary Admission form, the IE determined that the individual:

- Is mentally ill
- Does not present imminent danger to self or others
- Is not substantially unable to care for self as a result of mental illness
- Does not require involuntary hospitalization

The IE said that the results of his evaluation are always recorded on the Physician's Examination portion of the Proceedings for Certification form. This form is delivered to the SJ by a hospital employee who coordinates activities related to the hearings for the hospital (hospital liaison). The IE also reported that he often informally suggests or recommends the form of treatment that may be appropriate. When this does occur, his suggestion is passed to the SJ by the same hospital liaison. The IE did not attend the commitment hearing for the individual and reported that this is consistent with his normal practice of returning to his business office after all evaluations have been completed.

In talking with St Albans Behavioral Health Center personnel, the IE and the SJ, the OIG learned that the length of the temporary detention at St Albans Behavioral Health Center is primarily determined by the day of the week that the subject is admitted. Commitment

hearings are held on Monday, Wednesday and Friday mornings. When the individual was hospitalized in December of 2005, it was the practice of the Special Justices in the community to hold hearings at 11:00 a.m. This time has since been moved to 9:00 a.m. on the same three days each week. Any person who is admitted on a Sunday, Tuesday or Thursday would likely spend 24 hours or less in the hospital. If admitted at midnight on one of these days, the hospital stay could be as short as ten hours or so. A person admitted on Monday, Wednesday or Friday would automatically have a longer period of time in the hospital for observation.

Hospital personnel reported that the only information that is available to them regarding the detained patient is the Uniform Pre-Admission Screening form. If family members are available they can be a second source of information. Because there is so little time preceding the commitment hearing, there is not time to seek additional collateral information before the hearing. Several hospital staff with whom the OIG spoke reported that it is very difficult to complete required medical and psychiatric assessments and finish necessary paperwork prior to the commitment hearing for those patients who have less than 24 hour stays in the hospital. In addition to completing the usual discharge summary that is required by the hospital, it is routine for the attending physician to provide a suggestion regarding what form of treatment may be appropriate following the commitment hearing for those individuals who have been detained. The hospital completes a form entitled Initial Contact For TDO Admissions for all detained patients. This form includes the attending physician's recommendation for treatment following discharge. This form is routinely passed on to the SJ at the time of the hearing.

At St. Albans, the hospital liaison completes a TDO/Hearing Log for each day that hearings are being held. For each person who will go before the SJ, this log records the name, TDO#, insurance information, name of the attending physician, whether or not the family is present, whether or not the petitioner is present, the attending physician's recommendation for inpatient or outpatient treatment and the IE's recommendation for inpatient or outpatient treatment, the outcome of the hearing, the provider or agency to which the patient is referred, and the initials of the hospital employee who notified the receiving provider or agency.

On the morning of December 14, 2005, before the commitment hearing, the hospital liaison contacted the Cook Counseling Center to make an appointment for the individual. The Counseling Center did not make the appointment through the liaison, but insisted that the individual make his own appointment directly, as is consistent with standard practice at the Center. The phone was passed to the individual who spoke with the Counseling Center representative to make an appointment for 3:00 p.m. that same afternoon.

Prior to the commitment hearings that are held at St Albans, it is standard practice for the appointed attorney to bring all persons who have been detained together in a room and explain the hearing process and their rights. Each person is given an opportunity to meet privately with the attorney, if desired. Prior to each person's hearing, the attorney advises each individual and family (if available) privately of the medical findings and

recommendations. It is standard practice in Montgomery County for Paul M. Barnett and Terry W. Teel to alternate roles every month. During the month of December 2005, Paul Barnett was serving as Special Justice. On December 14, 2005, Special Justice Paul Barnett appointed Attorney Terry Teel to serve as counsel for the individual as per Va. Code § 37.2-814(C).

As noted by the SJ on the Proceedings for Certification for Involuntary Admission, a hearing was requested for the individual. Between 11:00 a.m. and 12:00 p.m. on December 14, 2005, a commitment hearing was held for the individual at St. Albans Behavioral Health Center. The OIG was informed by the SJ that because the New River Valley CSB does not send representatives to the commitment hearings to share the results of the prescreening and be available to answer questions, it is standard practice for the attorney representing the individual to read the contents of the Uniform Pre-Admission Screening form into the record. CSB representatives reported that they do not send the prescreener to the hearings because they cover six hospitals and do not have adequate staff to do this. The police officer that served as petitioner on the TDO was not present at the hearing. The roommate to whom the individual communicated that he might be suicidal and the roommate who provided collateral information were also not present.

As a result of this commitment hearing, the SJ recorded on the Proceedings for Certification form:

- That the individual presents an imminent danger to himself as a result of mental illness.
- That alternatives to involuntary hospitalization and treatment were investigated and were deemed suitable and that there is a less restrictive alternative to involuntary hospitalization and treatment in this case.

The SJ directed that the person receive treatment in accord with the following order: "Court-Ordered O-P (outpatient) – to follow all recommended treatments". The hospital liaison reported to the OIG that he faxed information regarding the outcome of the hearing to the CSB and discharge information to the Cook Counseling Center.

In separate interviews with CSB personnel and the IE, the OIG learned that approximately 10% of commitment hearings in the area result in court ordered outpatient treatment. St Albans personnel estimated slightly higher, closer to 20%. As specified in Va. Code § 37.2-817(C), the New River Valley CSB did not recommend a specific course of treatment and programs for the provision of involuntary outpatient treatment in this case. CSB representatives reported that this has never been their practice.

The individual was discharged from St. Albans Behavioral Health Center at 2:00 p.m. on December 14, 2005.

In interviews with the administrative and clinical staff of the Cook Counseling Center (CCC) at VA Tech, the OIG learned that the center does not accept involuntary or ordered referrals for treatment from any source including other departments of the university, outside agencies and the courts. CCC will not report to outside agencies

(including the courts) regarding treatment because it disrupts the voluntary nature of the service and it takes too much time away from direct services to other students. Anyone who needs treatment and will not come in voluntarily is referred to an outside agency. A student who is dangerous to self or others would only be treated at CCC center willingly or voluntarily. If these students are not willing to be treated voluntarily, they are referred to the New River Valley CSB. The CCC will not accept referrals as a part of disciplinary action by the university. Students who are disruptive to the university community are only treated if willing to be served. The majority of the students who are served by CCC are experiencing anxiety, depression and relational issues with other students. CCC provides treatment related to substance abuse issues only if the substance abuse is a secondary issue. CCC staff reported that they are serving increasingly "complex students". They do provide services for students with thought disorders and follow a number of these cases throughout their college career; however, the student must be willing to be served. Approximately 20 to 25% of the students who are served at CCC see a psychiatrist or a psychiatric nurse practitioner and may be receiving medication as needed. Students with eating disorders or severe substance abuse problems are referred to outside resources. Cases that require long-term therapy are also likely to be referred out. CCC staff reported that all referrals receive a "triage appointment" within 24 hours, either face-to face or by telephone. The director of CCC serves on the Care Team, along with representatives of other offices of the university. The director brings back information about students who are discussed at these meetings, but does not share information with the Team about any student who receives services at CCC. The director of Judicial Affairs reported to the OIG that they do not use mandated counseling with students because CCC will not accept these referrals. They do not make mandated referrals to outside agencies or professionals because the cost is too high.

On December 14, 2005, a VA Tech police officer notified the Assistant Director of Residence Services in the Summit Community where the individual lived about their involvement with the individual related to the harassment incident and the TDO. This information was then forwarded by email to a number of university personnel in Student Programs.

From December 14, 2005 to April 16, 2007

The investigation by the OIG did not reveal any new incidents or problem behaviors involving the individual from December 13, 2005 to April 16, 2007 when the critical incident occurred. There are only three documented contacts during this period of which the OIG is aware. The first was a May 2006 request by the individual to extend his stay in the dorm at the end of the semester, which was denied. Residence Life staff reported that this was a routine request. The second was a speeding ticket (74 in a 55 mph zone) issued by the Montgomery County Sheriff's Office on March 30, 2007. The third was a speeding ticket (44 mph in 25 mph zone) issued to him by the VA Tech Police on April 7, 2007, while driving a rented van. As far as the OIG was able to determine, there were no more reports or complaints about his behavior from students or faculty. His roommate and suitemates who described him during this period said he never made eye contact, frequently stared into space "as if he were thinking about something" and usually did not

respond if spoken to except for one word answers on occasion. They said he spent all of his time alone, was not known to have any friends, ate alone and kept a very regular schedule of going to bed at 9:00 p.m. and getting up at a consistent time each day. Those who described him during this period said they never saw him appear confused, disorganized or paranoid. They never noticed him talk to himself, make odd gestures or appear agitated. All said that he appeared mildly sad, but never significantly depressed and was never noted to cry or show any emotion. None saw any signs of violence and none noticed any weapons. All said, "I didn't really know him." During the period from the TDO and hospitalization in December 2005 until the critical incident on April 16, 2007 there were no incidents involving the individual of which the OIG is aware and he was more isolated from others.

The New River Valley CSB did not monitor the individual's compliance with the treatment ordered by the court. CSB staff reported to the OIG that they are routinely informed of the outcome of all hearings and that they have always understood that they are responsible for tracking only those persons who are committed to outpatient treatment at the CSB. They stated that they understood the Virginia Code to say that the designated provider is to monitor compliance.

V. Findings and Recommendations

Implementation of Emergency Custody, Pre-Admission Evaluation, and Temporary Detention

The process established in Virginia Code for responding to persons who are experiencing mental health crises and determining the need for involuntary treatment is initiated by taking the person into emergency custody, conducting a pre-admission screening to determine if criteria are met, and issuing a TDO by a magistrate. The OIG's investigation of this phase of the commitment process focused primarily on the pre-admission screening by the CSB but also examined the execution of each step in this process. The OIG examined compliance with the requirements of the Virginia Code and factors that may have supported or hindered the successful completion of the pre-admission screening. Following are the findings:

Emergency custody

- VA Tech Police Department (VTPD) responded immediately to an expressed concern by a reliable informant that a student had communicated suicidal ideas and might be at risk of harming himself. Police officers proceeded to the individual's dorm with no delay.
- The responding officer interviewed other informants, notified the On Call Coordinator in the individual's dorm, and then interviewed the individual once he was located. After concluding that there was sufficient information to take the individual into emergency custody as per Va. Code § 37.2-808(F), the officer transported the individual to the VTPD offices and contacted the New River Valley CSB ACCESS office right away to request a preadmission screening.

Pre-admission Screening

- The CSB prescreener traveled to the VTPD to conduct the preadmission screening, which is standard practice. This prevents the need to transport the individual to an alternate setting and enables the prescreening evaluation to begin as quickly as possible.
- The prescreener met all of the qualifications established in Va. Code § 37.2-809(A) for the definition of a "designee of the local community service board". In addition to being a Certified Prescreener, she was an experienced Licensed Clinical Social Worker (LCSW).
- As required by Va. Code § 37.2-809(B), the prescreener conducted an in person assessment. This evaluation included the gathering of collateral information, completion of a mental status exam and clinical assessment, formulation of a diagnostic impression, and making recommendations for pre-detention disposition, treatment, and discharge planning.
- After collecting evidence associated with the emerging crisis, the certified prescreener determined that the individual met the criteria established in Va. Code § 37.2-809(D) for temporary detention, which stipulates that the person (i) has mental illness, (ii) presents an imminent danger to himself or others as a result of mental illness or is so seriously mentally ill as to be substantially unable to care for himself, (iii) is in need of hospitalization or treatment, and (iv) is unwilling to volunteer or incapable of volunteering for hospitalization or treatment.
- The certified prescreener determined the facility of temporary detention as outlined in Va. Code § 37.2-809(D). In this case, securing the facility of temporary detention occurred with a single phone call and no delay. The OIG was told that more typically there are extensive delays in securing a willing facility. This is consistent with findings in OIG Report #123-05, Access Finding 1 that identified inadequate capacity statewide for crisis stabilization programs, inpatient services and other mental health emergency services. Another contributing factor to admission delays, mentioned by those with whom the OIG spoke, is the fact that current "medical clearance" practices at public and private hospitals vary tremendously. This problem was identified in Access Finding 5 in the same OIG report and was addressed by the General Assembly in 2006 Budget language. DMHMRSAS, with the involvement of several other organizations, is currently implementing solutions to this concern. These two access issues make it very difficult for those involved in the TDO process to fulfill all requirements of this process within the four-hour limit of an emergency custody order.
- The facility of temporary detention in this case, St. Albans Behavioral Health Center, is an approved facility as specified in Va. Code § 37.2-809(D).
- The facility was identified on the Uniform Pre-Admission Screening Form and the TDO.

- The certified prescreener determined, prior to the issuance of the temporary detention order, the insurance status of the person as required by Va. Code § 37.2-809(D).

Issuance and execution of TDO

- The magistrate reviewed the evidence and determined the individual met the criteria as specified in Va. Code § 37.2-809(B) for issuance of a temporary detention order, which are outlined above.

- As specified in Va. Code § 37.2-810(A), the magistrate designated the law-enforcement agency to carry out the order and provide transportation. The VTPD transported the individual to the approved facility of temporary detention.

Other

- It took approximately 3 ½ hours from the time the VTPD took the individual into emergency custody to the issuance of the TDO by the magistrate. This is within the four hours allowed for emergency custody as per Va.Code § 37.2-808(H).
- On December 14, 2005, a VTPD officer notified the VA Tech Assistant Director for Residence Life in the Summit Community where the individual lived about their involvement with the individual on December 13, 2005 related to the harassment incident and the TDO. This information was then forwarded by email to a number of university personnel in Student Affairs.

Recommendation

- It is recommended that the number and capacity of secure crisis stabilization programs be expanded statewide in order to address the challenges frequently faced by prescreeners in securing a willing temporary detention facility in a timely manner.

Recommendations for consideration by VA Tech

- It is recommended that the procedure for VTPD notification of the university on call administrator and the counseling center on call psychologist be reviewed to assure that these notifications occur as quickly as possible once the emergency custody period has been initiated for students who are experiencing a psychiatric emergency.

- It is recommended that the role of the on call psychologist in the initial screening and service evaluation of students experiencing a psychiatric emergency be clarified. It will be important that any procedures developed related to this role take into consideration the given time limits established by Va. Code § 37.2-808(H), which governs the duration of an emergency custody order.

Assessment by the Prescreener, at the Detaining Facility, Examination by the Independent Examiner, and Presentation of Evidence and Testimony to the Special Justice

The Virginia Code establishes that once a Temporary Detention Order (TDO) has been issued by a magistrate, the individual is to be detained in an appropriate detaining facility; an evaluation is to be conducted by an independent examiner; and an attorney is appointed to represent the person whose involuntary admission is sought. The OIG's investigation of this phase of the commitment process focused primarily on the procedural and systemic factors that enable or impede the Special Justice to have access to or be presented with the necessary information, evidence, and testimony needed to sufficiently understand the context of the behaviors that led to the TDO and to accurately assess the individual's mental health and risk of dangerousness. Attachment C provides a framework for this phase of the OIG investigation.

Assessment by Certified Prescreener

- In addition to interviewing and observing the individual, the prescreener considered information provided by three collateral sources in order to complete her assessment. This included the police report, an interview with the police officer and a phone interview with a roommate from the individual's suite. This roommate was selected because the roommate who had reported the individual's comment about suicide could not be available within the four-hour limitation for emergency custody. Based on her assessment, the prescreener recommended disposition was "Involuntary hospitalization because client meets criteria for involuntary hospitalization, is capable of consenting to voluntary treatment, but is unwilling to be treated voluntarily". Based on the prescreener's assessment, the magistrate determined that there was "probable cause" to detain the individual.

- The prescreener completed all portions of the Uniform Pre-Admission Screening form. She provided the details of the present situation and explained in some detail her clinically significant findings.

- The information provided on the Uniform Pre-Admission Screening form fully supported the recommended disposition.

- The prescreener provided the completed Uniform Pre-Admission Screening form to the hospital in a timely fashion so that it was available for the attending physician, the independent examiner and the Special Justice to consider.

Psychiatric Assessment and Evaluation by the Attending Psychiatrist at the Facility of Temporary Detention

The legal requirements for assessment of the detained person in the TDO/Commitment process proceed in tandem with, but quite independently from, the psychiatric

assessments and interventions provided by the detaining facility. While the attending psychiatrist and clinical team in the detaining facility does not have a defined role in the commitment process, the clinical assessments and observations they make provide valuable information about the detained person.

- VTPD records indicate that the individual was delivered to the approved facility of temporary detention (St Albans Behavioral Health Center) on December 13, 2005 at 10:49 pm as ordered by the magistrate in accord with Va. Code § 37.2-810(A). He was admitted to the facility at 11:15 p.m.

- Standard practice in medical settings is for the attending psychiatrist, with the help of nursing staff, social workers, and discharge coordinators to obtain as much collateral information as possible when completing the psychiatric evaluation, assessment, and treatment plan. This information is used in developing the individual's risk assessment, biopsychosocial formulation, and discharge plan. St Albans Behavioral Health Center staff informed the OIG that there is typically not time to seek additional collateral information on most detained patients whose commitment hearing is scheduled less than 24 hours after admission.

- Issues of confidentiality are determined by a collection of statutes in the Virginia Code. The OIG conducted an informal phone survey on June 7-8, 2007 of 20 psychiatrists who function as attending psychiatrists at facilities approved to hold individuals as per Va. Code § 37.2-809(D). The OIG received 19 responses to the question: "If you are treating an individual who is admitted to your facility under a TDO, and you deem it necessary for the purposes of diagnosis, risk assessment, treatment, or discharge planning to obtain collateral information prior to the commitment hearing for an individual who is medically stable, do Virginia statutes permit you to do so if the patient refuses to sign a release of information?" The following results revealed that there is very inconsistent understanding by attending physicians regarding their access to collateral information regarding their patient when the person refuses to authorize access:

Attending Physician Responses	Number
Yes, always	3
Yes, if it's critical to decision making	6
I don't know, but I would	5
No, but I would if I needed to	3
Never	2
Refused to respond	1

- Activities associated with the commitment hearing for the individual began at approximately 7:00 a.m. on December 13, 2005 when the independent examiner conducted his evaluations of the individuals who would come before the SJ that morning. Discharge from the facility occurred at 2:00 p.m. on December 13, 2005. The time between admission and the beginning of commitment hearing activities was approximately 7 hours and 45 minutes. The time from admission to discharge was approximately 14 hours and 45 minutes.

- Depending on the day of the week on which an admission occurs, the standing Monday, Wednesday, Friday morning schedule for commitment hearings means that some patients remain in the hospital considerably less that 24 hours. St Albans Behavioral Health Center staff informed the OIG that the short timeframe from admission to the commitment hearing makes it very difficult and sometimes impossible to complete the physical exam and psychiatric evaluation, assessment, and treatment plan until after the commitment hearing is held.

- St Albans Behavioral Health Center staff reported that information is shared with the Independent Examiner and Special Justice when requested. It is standard procedure for the attending physician to provide the Special Justice with a recommendation regarding whether outpatient or inpatient treatment is appropriate following discharge

Examination by an Independent Examiner

- Independent examiner Roy Crouse, PhD is currently, and was at the time of his examination of the individual, a qualified independent examiner in accord with Va. Code § 37.2-815.

- In accord with Va. Code § 37.2-815, on December 14, 2005 at approximately 7:00 a.m., Independent Examiner Roy Crouse, PhD examined the individual face to face at St Albans Behavioral Health Center for approximately 15 minutes.

- The independent examiner in this case reports that it is his standard practice to conduct the examination face to face, in a private room and typically spends 10-30 minutes with each person. He typically does a brief psychiatric assessment that includes, but is not limited to, the information on the Physicians Examination section of the Proceedings for Certification for Involuntary Admission form. He typically does a risk assessment that includes whatever collateral information is available to him at the time of his examination. He reported that the only information that he routinely reviews is the Uniform Pre-Admission Screening form provided by the prescreener. He also reported that while he has access to the hospital's records regarding the subject of his evaluations and can seek information from the attending physician, he only does this when the case is unclear.

- In this case the independent examiner interviewed the individual for approximately 15 minutes. He reviewed the Uniform Pre-Admission Screening form and reviewed the individual's medical records. The independent examiner reported that the psychiatric evaluation, assessment, and treatment plan by the detaining facility's attending psychiatrist and the individual's physical exam had not been done at the time of his examination. He could not recall if the individual's lab work and diagnostic testing had been completed. He did not obtain any further collateral information.

- It is the independent examiner's understanding that he has access to all available information about the subject of his evaluation. This includes, but is not limited to, the psychiatric evaluation and assessment by the attending psychiatrist, other health care providers, medical records, the Uniform Pre-Admission Screening form, and informants who are available at the time of his examination. It is his understanding that he could obtain collateral information from pertinent people in the individual's life; however, he reported that he has "rarely found that necessary."

- Va. Code § 37.2-816 states that the CSB shall provide the preadmission screening report within 48 hours, or longer when a weekend is involved. This standard for delivering the prescreening report to the detaining facility does not assure that the report will be available to the independent examiner and the attending physician.

- The independent examiner's examination of the individual complied with Va. Code § 37.2-815 which states that the role of the independent examiner is to personally examine the individual in private and determine to the standard of "probable cause" that

> The person (i) does or does not present an imminent danger to himself or others as a result of mental illness or is or is not so seriously mentally ill as to be substantially unable to care for himself and (ii) requires or does not require involuntary inpatient treatment.

Independent Examiner's Report to the Special Justice

- The only information required by the Virginia Code to be included in the independent examiner's report is that

> He has personally examined the person and has probable cause to believe that the person (i) does or does not present an imminent danger to himself or others as a result of mental illness or is or is not so seriously mentally ill as to be substantially unable to care for himself and (ii) requires or does not require involuntary inpatient treatment (§ 37.2-815).

- Neither the Virginia Code nor the Physician's Examination section of the Proceedings for Certification for Involuntary Admission form require the independent examiner to include in his report any recent history that might be helpful to understand the stressors precipitating the psychiatric emergency, any unique stressors that the individual will be returning to upon discharge from the detaining facility, a psychiatric history, a medical history, a list of medication, a history of head injury, a history of violent or impulsive behavior, a diagnosis, or any assessment except the minimum required as stated above. There is no expectation that the independent examiner attempt to account for any discrepancies between his assessment of the person and the assessment by the prescreener.

- The independent examiner in this case reported that after his examination of the individual he recorded the results of his evaluation on the Physician's Examination portion of the Proceedings for Certification form as is standard practice. He reported that his examination was based primarily on the information provided on the Uniform Pre-Admission Screening form and the information provided to him by the individual.

- The independent examiner in this case reported that the completed screening form was delivered to the Special Justice by a hospital liaison as is standard practice. He also reported that he did not attend the commitment hearing for the individual but was available to answer questions by phone as is the norm. He reported that the Special Justice only calls for additional information when clarification is needed and that this seldom occurs.

Presentation of Information, Evidence, and Testimony to the Special Justice

- On December 14, 2005, Special Justice Paul Barnett conducted a commitment hearing for the individual in accordance with Va. Code § 37.2-814 -818. Per the Proceedings for Certification for Involuntary Admission Form, the individual was unwilling to accept voluntary admission and treatment at that time.

- Based on information shared with the OIG by the Special Justice and the St Albans Behavioral Health Center liaison to the commitment hearings, the following summarizes the information that is routinely available to the SJ at the hearings:
    - Following the completion of the IE's evaluation of the person, the hospital liaison provides the Proceedings for Certification for Involuntary Admission form, including the completed Physician Examination section to the SJ.
    - The hospital liaison informs the SJ of both the hospital attending physician's recommendation and the IE's recommendation for whether inpatient or outpatient treatment is appropriate.
    - The attorney is present in the hearing to represent the person
    - The attorney for the person reads the Uniform Pre-Admission Screening form at the beginning of the hearing, and a copy of this form is available to the SJ.
    - The person who is the subject of the hearing is present to respond to questions from the attorney and the SJ.
    - Family members or other concerned parties may be present
    - The St Albans Behavioral Health Center liaison is available to obtain information but not present throughout the hearing.

- Based on information from the SJ, the OIG learned that the following individuals may be present at the hearing if available:
    - Petitioner

- Family members and other concerned parties

- Based on information from the SJ, IE and hospital staff, the OIG learned that the following individuals are routinely not present at the hearings and all three parties informed the OIG that they were not present at the commitment hearing for the individual on December 14, 2005.
  - Independent examiner
  - Attending physician
  - Prescreener or other representative of the CSB

- According to the requirements of the Virginia Code for representation at commitment hearings, all persons who are required to be present are routinely present at the hearings that are held at St Albans Behavioral Health Center. The Code allows for written submission of the IE's report and preadmission screening report.

Summary of Findings Related to Prescreening, Assessment at the Detaining Facility, Examination by the Independent Examiner, and Presentation of Evidence and Testimony to the Special Justice

The OIG investigation of this phase of the commitment process revealed that the Certified Prescreener, the detaining facility, and the IE all performed their responsibilities in connection with the December 14, 2005 commitment hearing for the individual in compliance with the requirements of the Virginia Code.

It was learned through the investigation of this critical incident, and the related review of the standard practices and procedures for the commitment process in the New River Valley area, that the current construct of the Virginia commitment process, as established by Virginia Code and common practice, may limit the collection and interpretation of vital collateral information.

Assessing an individual's mental health and level of dangerousness, especially in the setting of an evolving psychological crisis, is often a very difficult task. Good psychiatric and risk assessment require accurate knowledge about many aspects of an individual's life. When an individual is denying dangerousness and/or mental illness, and is not overtly dangerous and/or mentally ill on a mental status exam, but has recently deteriorated to the point of meeting the requirements for court ordered detention to ensure safety, it is imperative that the examiner not rely solely on the statements of the individual in crisis and the necessarily abbreviated assessment obtained for the TDO. The examiner should also obtain additional collateral information to expand, clarify, or refute the limited information available and the information provided by the individual. This collateral information helps to elucidate the broader context in which the crisis occurred.

Recommendation

- It is recommended that a comprehensive study of the commitment process in Virginia be conducted to determine the changes necessary to facilitate the collection and interpretation of critical collateral information that may be necessary for the assessment of an individual's mental illness and dangerousness in a broader context than is frequently achieved with the limitations of the current Virginia Code and practice.

Implementation of the Court Order

As recorded in the Proceedings for Certification for Involuntary Admission form, Special Justice Paul Barnett directed that the individual receive treatment in accordance with the following order: "Court-Ordered O-P (outpatient) - to follow all recommended treatments". The focus of the OIG investigation related to this order was to identify the factors that may have supported or impeded successful compliance with this order and all orders for outpatient commitment statewide. Following are the findings:

Designation of the provider

- The Special Justice ordered a specific form of treatment (outpatient). The order did not include designation of the specific agency or professional that was to deliver the service. (This is not required currently by Code.)

- Virginia Code § 37.2-817(C) refers to "designated provider" but does not clarify how or by whom the provider is designated.

- As is standard practice at St Albans Behavioral Health Center, the hospital liaison facilitated the discharge process by assisting the patient in making an outpatient appointment. In the Montgomery County area, for patients who do not have resources, the CSB is the only affordable outpatient service unless the patient is a student of a local university. The liaison facilitates the process by making the appointment for the individual. If the agency insists on making the appointment directly with the patient, the liaison hands the phone to the patient who makes the appointment. The liaison then speaks with the agency representative to confirm that the appointment has been made. In this case, the appointment was made voluntarily, directly by the patient with the VA Tech Cook Counseling Center for 3:00 p.m. on December 14, 2005, the afternoon of the commitment hearing.

- The Cook Counseling Center at VA Tech does not accept involuntary or ordered referrals from any source, including other departments of the university, outside agencies or courts. All clients who are served at the Center must be willing to receive services and must come voluntarily.

- By assisting with the execution of a referral in connection with the outcome of a commitment hearing, the hospital liaison plays two separate roles:
    - On behalf of the hospital, he assures that the discharge plan established or recommended by the attending physician is carried out. This is a critical hospital function that is required for every patient of the hospital.
    - On behalf of the court, he assists in implementing the court order. This role is carried out as an undesignated agent of the court.

- It is standard practice for the hospital liaison to notify the local CSB regarding the outcome of all commitment hearings and to send various documents, including the hospital discharge summary, to the receiving inpatient facility or outpatient agency. The New River Valley CSB was notified of the outcome of this commitment hearing. The hospital liaison did send the usual packet of records to the Cook Counseling Center.

- It is not a part of the hospital liaison's standard practice to assure that the provider who is selected to deliver the outpatient treatment is willing to accept court ordered referrals or that the provider understands the Virginia Code responsibilities associated with providing court ordered outpatient treatment.

- Staff of the St Albans Behavioral Health Center and the Cook Counseling Center reported a severe lack of outpatient services in the New River Valley area. A survey of the 40 CSBs conducted by the OIG during the week of June 4, 2007, provided information about the average number of days a person seeking services must wait for the first outpatient appointment with a counsel and with a psychiatrist. This information was collected separately for adults and children/adolescents. Appointments in non-crisis situations and appointments following an emergency intervention were also separated. This survey is based on the past six months of services delivery and had a 100% response rate. This survey revealed that Virginians who seek outpatient services at local CSBs have long waits.

CSB Average Wait Time for Outpatient Services		
	Adults (days)	Children (days)
Outpatient appointment	35	35
Psychiatrist appointment	12	15
Outpatient – post emergency	23	30
Psychiatrist – post emergency	13	15

- This same OIG survey of the 40 CSBs revealed that over the past 10 years, CSB outpatient capacity has decreased for 57.5% of the CSBs in adult services and 50% of the CSBs in child/adolescent services.

Change in CSB Outpatient Capacity Over Past 10 Years				
	Adults		Child/Adolescent	
	Number of CSBs	% of 40 CSBs	Number of CSBs	% of 40 CSBs
Increased Capacity	7	17.5%	16	40%
Decreased Capacity	23	57.5%	20	50%
No Change	10	25%	4	10%

CSB Role

- The New River Valley CSB that serves Montgomery County did not recommend a specific course of treatment and programs for the provision of involuntary outpatient treatment as specified in Va. Code § 37.2-817(C).

- It has been standard practice for the New River Valley CSB not to attend commitment hearings. No staff representative from the CSB was present at the December 14, 2005 commitment hearing for this individual.

- The June 4, 2007 OIG survey also revealed that the average estimated percentage of commitment hearings that were attended by the 40 CSBs in the past six months was 54.25%. The following chart provides further detail from this survey:

Range of Estimated % of Hearings Attended by CSB	Number of CSBs	% of 40 CSBs
96 – 100%	16	40%
76 – 95%	4	10%
51 – 75%	1	2.5%
26 – 50%	2	5%
1 – 25%	8	20%
0%	9	22.5%

- This same OIG survey of the 40 CSBs revealed the following barriers to attendance at commitment hearings:

Barrier to CSB Participation in Hearings	Number of CSBs	% of 40 CSBs
Limited staffing	19	48%
Travel distance (within service area)	8	20%
Hearing outside of service area	10	25%

Compliance monitoring and intervention

- Virginia Code § 37.2-817(C) does not clarify the role of the CSB, behavioral health authority (BHA) or designated provider in monitoring the person's compliance with the outpatient treatment order. While it states that compliance must be monitored and that failure to comply may be admitted into evidence in subsequent hearings, it does not specify any responsibility for the CSB, BHA or provider if the patient does not comply. The New River Valley CSB has not historically reported noncompliance to the court.

- The Cook Counseling Center has a standard practice of not reporting to outside agencies, including the courts, regarding treatment provided to their clients. The New River Valley CSB only monitors involuntarily ordered outpatient clients who receive treatment at the CSB.

- Virginia Code § 37.2-817(C) states, "Upon failure of the person to adhere to the terms of the outpatient treatment order, the judge or special justice may revoke it and, upon notice to the person and after a commitment hearing, order involuntary admission to a facility." CSBs and special justices in some communities are unclear regarding the authority of the special justice to hold another commitment hearing for an individual who fails to comply with ordered outpatient treatment unless there is clear evidence that new behaviors that meet the TDO or commitment criteria are currently present.

Recommendations

- It is recommended that consideration be given to requiring by Virginia Code that the name of the provider(s) that are to provide the involuntary outpatient treatment be designated in the court order.

- It is recommended that the responsibility of the CSB to recommend a specific course of treatment and programs for the provision of involuntary outpatient

treatment, as specified in VA Code § 37.2-817(C), be further defined by Virginia Code, regulation or policy.

- It is recommended that a study be conducted to:
  - Identify the barriers that prevent or complicate CSB/Behavioral Health Authorities (BHA) attendance at commitment hearings statewide and recommend solutions. Once these barriers are fully understood and a plan is developed to resolve the barriers, determine whether or not the Virginia Code should be amended to require CSB/BHA attendance at all commitment hearings.
  - Determine what barriers prevent or complicate CSB/BHA's statewide from routinely recommending a specific course of treatment and programs for the provision of involuntary outpatient treatment as specified in Va. Code § 37.2-817(C) and develop a plan to address these barriers.

- It is recommended that a study be conducted to determine whether or not the following duties should be carried out by the court or by another entity acting as an official agent of the court, instead of the hospital or facility where the temporary detention occurred:
  - Locating a willing outpatient provider to provide court ordered outpatient treatment.
  - Arranging for the initial outpatient appointment.
  - Providing a copy of the court order to the receiving provider.
  - Notifying the CSB/BHA of the outcome of the commitment hearing.

  If, as a result of this study, it is determined that an entity serving as an official agent of the court should carry out these functions, changes in Code, regulation or policy should be made to designate this entity.

- It is recommended that the court's expectations for outpatient providers who provide treatment to individuals who have been ordered to outpatient treatment be clarified, by Code, regulation or policy.

- It is recommended that the expectations of the CSB, BHA or designated provider to monitor the person's compliance with the treatment ordered by the court as per Va. Code § 37.2-817(C) be clarified by Code, regulation or policy. Specifically address what action is to be taken by the CSB, BHA or designated provider in relationship to the court when the person fails to comply. Also clarify what role, if any, the CSB or BHA has for monitoring treatment when the designated provider is not the CSB or BHA.

- It is recommended that a mechanism be developed to assure that outpatient providers, who provide treatment to individuals who have been ordered to outpatient treatment, understand the responsibilities to the court when accepting these referrals.

- It is recommended that the criteria that must be met for the judge or SJ to hold a second commitment hearing when the person fails to comply with the earlier order to outpatient treatment be clarified in Va. Code § 37.2-817(C).

- It is recommended that a study be conducted to determine what level of community outpatient service capacity will be required and the related costs in order to adequately and appropriately respond to both involuntary court ordered and voluntary referrals for these services.

Recommendations for consideration by university counseling centers in the Commonwealth

- It is recommended that university counseling centers develop a written policy regarding:
    - Whether or not the center will accept referrals for court ordered involuntary treatment, and if so, the types of referrals they can accept.
    - Whether or not the center will report treatment related information to the courts and/or the CSB when the client is under order to receive court ordered treatment.

- It is recommended that university counseling centers notify the courts, CSBs and BHAs in their surrounding cities and counties of this policy.

- It is recommended that the university counseling centers develop criteria and procedures for providing required treatment to students who have been deemed in need of mental health services and for whom the treatment is a part of a university support plan for these students.

VI. Acknowledgement

The staff of the Office of the Inspector General who investigated this critical incident express a deep appreciation to all of those from within and outside the university community who took the time to talk with us about the events and services that surrounded the April 16, 2007 tragedy that took place at Virginia Tech. Because so many individuals were willing to make themselves available on very short notice and remained accessible to the OIG in the days that followed our site visit to Blacksburg, a comprehensive understanding of what transpired in this critical incident was made possible. It is our intent and hope that the findings and recommendations will enable improvement in the system of mental health services in the Commonwealth of Virginia and that future tragedies can be prevented.

Attachment A

Persons Interviewed by the OIG
Investigation of April 16, 2007 Critical Incident at Virginia Tech

A. New River Valley Community Services Board
- Director of Adult Clinical Services
- Prescreener (former employee)
- Coordinator of Access

B. Carilion Saint Albans Behavioral Health (New River Valley)
- Nurse Practitioner
- Psychiatric Technician
- Clinical Team Leader
- Registered Nurse
- Manager of CONNECT
- Attending Psychiatrist
- Registered Nurse
- Patient Representative

C. Virginia Polytechnic Institute and State University
- Office of University Legal Counsel Attorney

Cook Counseling Center
- Psychiatric Nurse Practitioner
- Counselor
- Receptionist
- Director
- Director of Training
- Assistant Director of Clinical Services
- Post Doctoral Fellow

Student Programs
- Dean of Students
- Resident Assistant
- Assistant Vice President for Student Affairs
- Director of Judicial Affairs
- Associate Vice President for Student Affairs
- Assistant Director for Judicial Affairs
- Resident Advisor for Chochrane Hall (former)

Virginia Tech Police Department
- Captain
- Captain

Students

D. Special Justice

E. Independent Evaluator

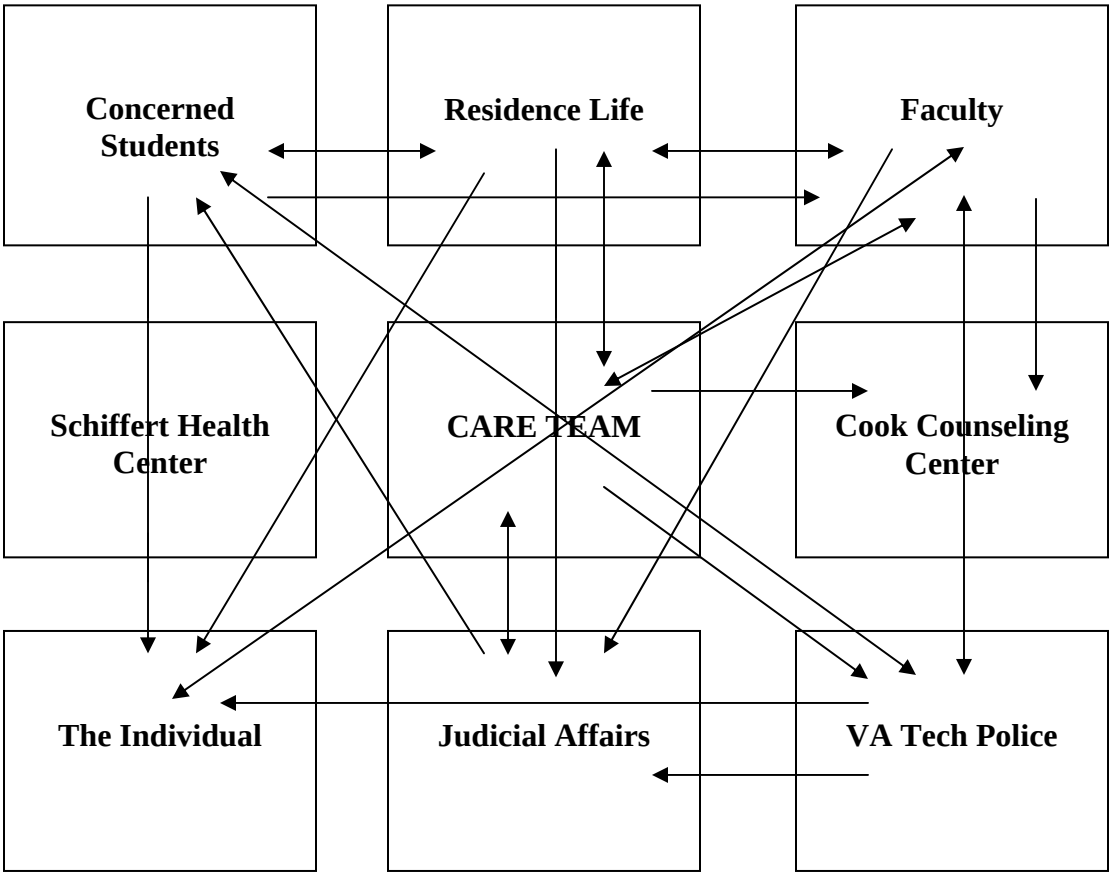
F. Office of Licensure - Department of Mental Health, Mental Retardation and Substance Abuse Services
Director
Licensing Specialist, Southwest Virginia

Documents Reviewed:

1. Uniform Pre-Admission Screening Form for "the individual" dated December 13, 2005
2. Temporary Detention Order for "the individual" dated December 13, 2005
3. Proceedings for Certification for Involuntary Admission to a Public or Private Licensed Mental Health Facility for "the individual" – Petition dated December 13, 2005
4. Virginia Tech Police reports related to "the individual"
5. Documents protected by the HIPAA Privacy Rule, the Virginia Health Records Privacy Act and Virginia Code § 37.2-424(4):
    a. Cook Counseling Center records
    b. St. Albans Behavioral Healthcare records
    c. Schiffert Health Center records
6. Documents protected by Va. Code § 37.2-818:
    a. Audio tape of December 14, 2005 commitment hearing for "the individual"

Attachment B

Diagram of Communications Regarding the Individual Within the Virginia Tech Community – Fall 2005*



* This diagram in no way reflects communication that may or may not have occurred between the individual and offices of the university that maintain patient information and records that are protected by federal privacy regulations, including the HIPAA Privacy Rule, 45 C.F.R. Parts 160 and 164, the Virginia Health Records Privacy Act, § 32.1-127.1:03, and Va. Code § 37.2-424(4) and in no way reflects communication that may or may not have been initiated by these same offices.

Attachment C

Toward a Better Understanding of Psychiatric Emergencies, Assessment for Dangerousness and Effective Interventions To Assure Safety and Enable Recovery

To assist the Virginia Office of the Inspector General for Mental Illness, Mental Retardation and Substance Abuse Services (OIG) in preparing to investigate the April 16, 2007 critical incident at VA Tech, Kent G. McDaniel, MD, PhD, consulting psychiatrist to the OIG and a member of the investigation team, developed this paper to help the team establish a common framework for examining the assessment and intervention aspects of the commitment process.

Psychiatric Emergencies

Psychiatric emergencies always occur within the context of an individual's life and psychological development. They are typically preceded by an emotionally significant event or a series of events that create overwhelming challenges to an individual's beliefs and coping mechanisms. The individual's normal pattern of coping, no matter how functional or dysfunctional, deteriorates during this period, which typically lasts from a few days to months. When the individual fails to make the changes necessary to restore equilibrium, and his or her ability to cope deteriorates to the point that the individual can no longer function within his or her environment, the situation becomes a psychiatric emergency.

Assessing for Dangerousness

One of the most important aspects of crisis intervention in a psychiatric emergency is assessing for safety. If the individual's functional capacity has deteriorated to the point that the individual has become a danger to self or others, then establishing safety becomes a vital aspect of the intervention. The Virginia Code has established that if there is evidence that an individual is an imminent danger to self or others due to mental illness, or is substantially unable to care for self due to mental illness, then legal action can be taken to ensure safety until a thorough assessment of dangerousness can be completed.

Assessing an individual's dangerousness, especially in the setting of an evolving psychological crisis, is often a very difficult task. A reasonably good risk assessment requires accurate knowledge about many aspects of an individual's life. When an individual is denying dangerousness and is not overtly dangerous on a mental status exam but has recently deteriorated to the point of meeting the requirements for court ordered detention to ensure safety, it is imperative that the evaluator not rely solely on the statements of the individual in crisis, but obtain collateral information to corroborate, clarify, or refute the information the individual provides.

Additionally, the assessment itself, especially if it involves briefly removing an individual from his or her environment at the point of the immediate crisis, is often palliative enough to mitigate the psychological deterioration and reduce the dangerousness of an individual during the process of assessment. This effect, though beneficial to the individual and the community, compounds the complexity of assessing the risk of dangerousness because the deterioration that resulted in the psychiatric emergency occurred while the individual was attempting to cope with the demands of his or her normal environment. Risk assessment, therefore, requires the evaluator to estimate the dangerousness of an individual not only in the setting of the assessment, but also in the various environments to which the individual will be returning, and in the context of the psychological crisis which precipitated the psychiatric emergency. **Therefore, an accurate assessment of dangerousness in an individual temporally detained under a magistrate's order can only be accomplished by specially trained professionals who have done a thorough psychiatric evaluation and assessment using sufficient collateral information to ensure an accurate understanding of the individual, the individual's environment, his recent behaviors, and the context of the psychological crisis that precipitated the psychiatric emergency which warranted a temporary detention order.**

Effective Interventions

Events that occur at the time of a psychiatric emergency can, and typically do, have life long effects upon the individual. The psychological crisis underlying the psychiatric emergency dictates that the individual must respond to his or her impulses and environments in new ways. The individual can no longer maintain his or her level of functioning in the same environment relying on the same coping mechanisms. The individual either develops more adaptive beliefs and coping strategies and grows into higher levels of functioning, or the individual retreats into less adaptive beliefs and coping strategies and regresses to lower levels of functioning. Effective interventions at the time of a psychiatric emergency not only ensure safety, reduce suffering, and mitigate the deterioration of adaptive functioning occurring at the time of the immediate crisis, but effective interventions also encourage the individual to resolve the crisis positively toward a more adaptive lifestyle. Intervention strategies can be considered ineffective when they do not ensure safety, reduce suffering, mitigate the deterioration at the time of the immediate crisis, or fail to promote healthier life choices. **In short, interventions at the time of a psychiatric emergency are not only a means to ensure safety, but are often the pivotal means to engage or re-engage the individual into a process of recovery that promotes the future welfare of the individual and his or her role within the community.**